



BOARDING HOME DEMENTIA SCREENING TOOL

Name of individual: _____

The individual named on this form has been assessed and found to exhibit:

1. Evidence of short-term memory loss: Yes No
(If there is no evidence of short-term memory loss, the assessor may go to **4.b**, and skip 2 and 3.)

And

2. **One** or more of the following conditions: (Check all that apply)
- Is not oriented to place or time.
 - Has limited ability to make him or her self understood through speech, writing, sign language or any other method the individual uses to communicate.
 - Requires hands-on assistance with eating or drinking.
- (If there is no evidence of one of these conditions, the assessor may go to **4.b**, and skip 3.)

And

3. One or more of the following behaviors or symptoms which has been exhibited by the individual within the last thirty days: (Check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Ability to make decisions about daily life is poor; requires reminders, cues and supervision in planning daily routines | <input type="checkbox"/> Repetitive physical movement/pacing, hand-wringing, fidgeting |
| <input type="checkbox"/> History of physical injury to staff/others | <input type="checkbox"/> Leaves stove on after cooking |
| <input type="checkbox"/> Combative | <input type="checkbox"/> Aggressive/intimidating |
| <input type="checkbox"/> Resistive to care | <input type="checkbox"/> Exit seeking behaviors |
| <input type="checkbox"/> Sexual acting out (does not victimize others) | <input type="checkbox"/> Easily irritated/upset/agitated |
| <input type="checkbox"/> Seeks vulnerable or unwilling sexual partners | <input type="checkbox"/> Seeks/demands constant attention/reassurance |
| <input type="checkbox"/> Agitated or wanders at night | <input type="checkbox"/> Pattern of inability to control own behaviors.
Specify: _____ |
| <input type="checkbox"/> Eats non-edible objects | <input type="checkbox"/> Unrealistic fears or suspicions |
| <input type="checkbox"/> Inappropriate screaming, yelling or verbal noises | <input type="checkbox"/> Inappropriate toileting activity
Specify: _____ |
| <input type="checkbox"/> Has left home and gotten lost when trying to return | |

(If there is no evidence of one of these conditions, the assessor may go to **4.b**)

- 4.a.** The individual named on this form has identified characteristics of dementia in categories 1, 2, and 3 above.

Therefore:

- (1) The staff of any boarding home in which the named individual resides must meet the dementia specialty training requirements specified in Washington Administrative Code 388-112, and
- (2) The boarding home must obtain the assessment information for the individual as specified in WAC 388-78A-2370.

- 4.b.** This individual does not meet the screening criteria for dementia identified on this form.

QUALIFIED ASSESSOR
SIGNATURE

DATE